Public Employees Benefits Board (PEBB)

Student Certification/ Change Form

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- Please review instructions on the back side of this form before completing.

SECTION 1 Subscriber Information

Name | Social security number

Address | Phone

SECTION 2 Dependent Information (List one dependent *ONLY* per form)

Dependent name

Social security number | Birth date

Dependent upon subscriber for maintenance and support? ☐ Yes ☐ No

Complete For Enrollment

SECTION 3 School Information

Name | Registrar's phone

Quarters/Semesters/Trimesters Attended Full-Time

☐ Fall ☐ Winter ☐ Spring ☐ Summer | Academic year _____

SECTION 4 Subscriber Certification and Signature

I have read the WAC 182-12-119 (3) on the back of this form and I declare, under penalty of perjury, that the foregoing information provided by me is true and correct and that all provisions of this statement have been met. The Health Care Authority reserves the right to verify this information at any time.

Signature Printed copy must be signed by the subscriber Date _____

Complete This ONLY If No Longer Eligible

SECTION 5 Request to Terminate Dependent Coverage

The above-listed dependent is 20 years of age or older, is not a full-time student or disabled dependent, or has graduated, married, or emancipated, and is no longer eligible to be on my PEBB medical/dental coverage. I understand that this dependent's PEBB coverage will end effective the first day of the month following my date of signature below, unless termination is due to graduation. See instructions for Section 5 on the other side of this form.

Did the dependent graduate? ☐ Yes ☐ No Date _____

Signature Please sign printed copy to request termination Date _____

Washington State Health Care Authority
Public Employees Benefits Board

Washington State law may require disclosure of any information you submit as a public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at www.wa.gov/hca.

Completing the *PEBB Student Certification/Change Form*

Your child may be eligible to continue coverage as a student if he or she is:

- ✓ **Age 20 – 23**
  Children ages 24 and older do not qualify unless they have been approved for coverage as a disabled dependent, in which case form HCA 50-144 (*Request for Certification of Disabled Dependent*) needs to be completed.
- ✓ **Dependent upon the subscriber for maintenance and support** (housing, food, tuition, etc.)
- ✓ **A full-time student**
- ✓ **Attending at least three out of four quarters, or two semesters**

Dependents qualify as eligible for student coverage under PEBB based on the following rules:

WAC 182-12-119 (3) Dependent children age 20 through age 23 who are dependent upon the employee/retiree for maintenance and support, and who are registered students in full-time attendance at an accredited secondary school, college, university, vocational school, or school of nursing. Dependent student eligibility continues year-round for those who attend three of four school quarters, or two semesters, and for the quarter following graduation provided the employee/retiree is covered at the same time; the dependent limiting age has not been exceeded; and the dependent meets all other eligibility requirements.

Instructions

Section 1: Verify the subscriber's personal information. If any of the information shown is incorrect, please mark your changes within this space.

Section 2: Provide information for the dependent you are either requesting to cover as a full-time student or disenroll from your PEBB coverage. **Only list one dependent per form.**

Section 3: If your dependent is a full-time student, indicate the school's name and registrar's phone number.

Section 4: If your dependent is a full-time student, sign and date the form to certify that your dependent is eligible to continue his or her PEBB coverage.

Section 5: If your dependent is not a full-time student, or no longer qualifies to be enrolled on your PEBB coverage, sign and date the form here to terminate coverage for your dependent. If the student has graduated, he or she is **eligible for coverage for three months after graduation.** The HCA will notify you of that date and send you an application to allow your dependent to continue coverage on a self-pay basis for up to 36 months.

It is the responsibility of the subscriber to notify the Health Care Authority if there are any changes in the student's status throughout the year. For information on this form or for any questions on student status, please call 1-800-700-1555.

Mail completed form to: Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684, or fax to 360-923-2602.